

1-1-2016

Can a clinical placement influence stigma? An analysis of measures of social distance

Lorna Moxham

University of Wollongong, lmoxham@uow.edu.au

Ellie K. Taylor

University of Wollongong, elliejo@uow.edu.au

Christopher F. Patterson

University of Wollongong, cpatters@uow.edu.au

Dana J. Perlman

University of Wollongong, dperlman@uow.edu.au

Renee M. Brighton

University of Wollongong, reeneb@uow.edu.au

See next page for additional authors

Follow this and additional works at: <https://ro.uow.edu.au/smhpapers>



Part of the [Medicine and Health Sciences Commons](#), and the [Social and Behavioral Sciences Commons](#)

Recommended Citation

Moxham, Lorna; Taylor, Ellie K.; Patterson, Christopher F.; Perlman, Dana J.; Brighton, Renee M.; Liersch, Susan; Keough, Emily; and Heffernan, Tim, "Can a clinical placement influence stigma? An analysis of measures of social distance" (2016). *Faculty of Science, Medicine and Health - Papers: part A*. 4159.
<https://ro.uow.edu.au/smhpapers/4159>

Can a clinical placement influence stigma? An analysis of measures of social distance

Abstract

Background The way people who experience mental illness are perceived by health care professionals, which often includes stigmatising attitudes, can have a significant impact on treatment outcomes and on their quality of life. **Objective** To determine whether stigma towards people with mental illness varied for undergraduate nursing students who attended a non-traditional clinical placement called Recovery Camp compared to students who attended a 'typical' mental health clinical placement. **Design** Quasi-experimental. **Participants** Seventy-nine third-year nursing students were surveyed; n = 40 attended Recovery Camp (intervention), n = 39 (comparison group) attended a 'typical' mental health clinical placement. **Methods** All students completed the Social Distance Scale (SDS) pre- and post-placement and at three-month follow-up. Data analysis consisted of a one-way repeated measures analysis of variance (ANOVA) exploring parameter estimates between group scores across three time points. Two secondary repeated measures ANOVAs were performed to demonstrate the differences in SDS scores for each group across time. Pairwise comparisons demonstrated the differences between time intervals. **Results** A statistically significant difference in ratings of stigma between the intervention group and the comparison group existed. Parameter estimates revealed that stigma ratings for the intervention group were significantly reduced post-placement and remained consistently low at three-month follow-up. There was no significant difference in ratings of stigma for the comparison group over time. **Conclusions** Students who attended Recovery Camp reported significant decreases in stigma towards people with a mental illness over time, compared to the typical placement group. Findings suggest that a therapeutic recreation based clinical placement was more successful in reducing stigma regarding mental illness in undergraduate nursing students compared to those who attended typical mental health clinical placements.

Keywords

influence, distance, stigma?, social, placement, measures, analysis, can, clinical

Disciplines

Medicine and Health Sciences | Social and Behavioral Sciences

Publication Details

Moxham, L., Taylor, E., Patterson, C., Perlman, D., Brighton, R., Sumskis, S., Keough, E. & Heffernan, T. (2016). Can a clinical placement influence stigma? An analysis of measures of social distance. *Nurse Education Today*, 44 170-174.

Authors

Lorna Moxham, Ellie K. Taylor, Christopher F. Patterson, Dana J. Perlman, Renee M. Brighton, Susan Liersch, Emily Keough, and Tim Heffernan

Can a clinical placement influence stigma? An analysis of measures of Social Distance

SUMMARY

Background: The way people who experience mental illness are perceived by health care professionals, which often includes stigmatising attitudes, can have a significant impact on treatment outcomes and on their quality of life.

Objective: To determine whether stigma toward people with mental illness varied for undergraduate nursing students who attended a non-traditional clinical placement called Recovery Camp compared to students who attended a ‘typical’ mental health clinical placement.

Design: Quasi-experimental.

Participants: Seventy-nine third-year nursing students were surveyed; $n = 40$ attended Recovery Camp (intervention), $n = 39$ (comparison group) attended a ‘typical’ mental health clinical placement.

Methods: All students completed the Social Distance Scale (SDS) pre- and post-placement and at three-month follow-up. Data analysis consisted of a one-way repeated measures analysis of variance (ANOVA) exploring parameter estimates between group scores across three time points. Two secondary repeated measures ANOVAs were performed to demonstrate the differences in SDS scores for each group across time. Pairwise comparisons demonstrated the differences between time intervals.

Results: A statistically significant difference in ratings of stigma between the intervention group and the comparison group existed. Parameter estimates revealed that stigma ratings for the intervention group were significantly reduced post-placement and remained consistently low at three-month follow-up. There was no significant difference in ratings of stigma for the comparison group over time.

Conclusions: Students who attended Recovery Camp reported significant decreases in stigma towards people with a mental illness over time, compared to the typical placement group.

Findings suggest that a therapeutic recreation based clinical placement was more successful in reducing stigma regarding mental illness in undergraduate nursing students compared to those who attended typical mental health clinical placements.

Keywords: education, mental illness, stigma, student nurses, therapeutic recreation.

Introduction

It is well known that stigma has detrimental effects on the wellbeing of people with mental health issues. A substantial amount of research has been dedicated to demonstrating the effects of stigma. Such research has examined the impact of internalised stigma on people with a lived experience of mental illness (Boyd et al., 2014; Drapalski et al., 2013) the effect of stigma on the quality of care provided by health care professionals (Henderson et al., 2014), and strategies used in attempting to reduce stigma (Corrigan & Gelb, 2006; Griffiths et al., 2014).

Undergraduate nursing students engage in education about stigma, which includes the impact upon consumers, the impact on their efficacy in the work place, and how to avoid negative prejudices and discrimination against those under their care. It is important that students understand the impact of stigma to ensure that they can provide the highest possible health care for consumers (Hunter et al., 2015).

As part of their program of study, nursing students across the globe participate in mandatory clinical placements, which are an integral component of their learning and are thought to have an impact on attitudes toward mental illness (Chadwick & Porter, 2014).

Stigma

A wealth of research has demonstrated the debilitating effects of stigma towards people with a mental illness (Corrigan et al., 2014; Mestdagh & Hansen, 2013). Due to the plethora of descriptions as to what constitutes stigma provided by research, its application across different contexts, and the magnitude in which it impacts society and those with lived experience, it is often difficult to attain a single definition or theoretical approach (Phelan et

al., 2014). Like a stereotype, it is a negative perception toward a person or population based on unjust beliefs, commonly due to a lack of knowledge. The lack of power experienced by the individual remains a perpetuating factor in the level of social distance placed between them and society (Johnson, et al., 2014).

Discourse about stigma for people with a mental illness is longstanding. Corrigan (1998) explored the impact of stigma on people suffering from severe mental illness. He found that people who openly live with mental illness lack the ability to live independently, struggle to become employed and are unable to establish a basic income. Furthermore, he suggested they experience difficulties in relationships and have a poorer quality of life. These impacts, as well as social isolation, financial difficulties and secure housing, are perpetuating factors that make seeking help difficult for people with a mental illness. This creates a spiral effect, disabling people from receiving appropriate help from health care providers.

These consequences, in addition to the lack of continuity of care (Adair et al., 2005) and poor quality medical care (Miller et al., 2003) for this group of people present obstacles, which inhibit consumers' ability to improve their wellbeing and recovery. Stigma is learned, and concomitantly can be unlearned. It is often the result of misinterpreted information, which leads people to negatively perceive those living with mental illness (Corrigan et al., 2004). Such negative perceptions commonly illicit pessimistic expectations and discrimination, and represent a fundamental social injustice (Murman et al., 2014).

People with mental illness experience stigma because they are perceived as being different (Link & Phelan, 2006). Misconceptions regarding the differential characteristics associated with mental illness, such as being violent, dangerous, or unpredictable, influence the level of interaction society has with people living with mental illness. Discovering methodological ways to reduce stigma has been a specific goal for mental health research in the last decade (Cook et al., 2014). Studies have found that there are several strategies that

influence the level of stigma one feels towards mental illness; two of which are knowledge (Michaels et al., 2014) and contact (Ashe, 2015; Rosenberg, 2014).

Stigma and Education

One strategy to overcome stigma is education. Education involves teaching the general public about mental illness, including possible causes, symptoms, and effects on the person experiencing the illness (Couture & Penn, 2003). Schools and universities do this through course curriculum in an attempt to familiarise students with mental illness before setting out into the workplace. Understanding mental illness is a necessary step in breaking negative misconceptions about consumers, namely that they pose a threat to society and therefore should be discriminated against.

Studies have shown that interventions that provide knowledge about mental illness or contact with a person with mental illness are more efficacious in reducing stigma (Thornicroft et al., 2015). Familiarisation, or promoting contact with people who experience mental illness, is a strategy that can break down the negative stereotypes that construct the stigma initially. As a result, people exposed to this type of familiarisation may be less likely to distance themselves from a person with lived experience. By placing a person in direct contact with someone who has a mental illness, stigma can be reduced through combining new information and challenging negative beliefs (Ashe, 2015; Byrne et al., 2013).

It has been theorised that decreases in stigma are the result of a decrease in perceived danger regarding people living with mental illness. Angermeyer et al. (2004) demonstrated, using community college students, that people who were familiar with mental illness, for instance, people who were in close proximity to someone living with a mental illness, were less likely to perceive them as dangerous. This familiarity resulted in a diminished desire for

social distance. The most effective familiarisation techniques were based on an equal balance of status and power, such as team building exercises where people are required to work together. Working together provides people with an opportunity to observe the inconsistencies that exist between the negative stereotypes they hold with regard to a particular group and the positive interaction that occurred when collaborating with the person living with a mental illness. People who know someone (family member, friend, co-worker) who has a lived experience of mental illness also report a reduced desire for social distance, and less perceived danger of a person who is mentally unwell (Angermeyer et al., 2004). Such strategies can be utilised to decrease stigma, which is particularly important for future health professionals, such as the cohort presented in this paper.

Health Care Professionals and Stigma

The way people with mental illness are conceptualised by health care professionals can have a significant impact on treatment outcomes and on their quality of life (Bennetts et al., 2013; Stuber et al., 2014), the consequences of which are significant for consumers. A study by Nordt et al. (2006) explored the attitudes of mental health professionals toward people living with severe mental illness. Survey analysis showed that psychiatrists had more negative stereotypes regarding people with schizophrenia compared to the general population. Furthermore, the authors found no significant difference between desire for social distance between health care professionals and the general public. Nordt et al. (2006) concluded that health care professionals required significantly more comprehension and knowledge of mental health issues to ensure that high levels of support could be provided to people with mental illness. Such increased knowledge was thought to also positively change attitudes that were stigmatising.

As previously discussed, strategies thought to positively address stigma that are also pertinent for health care professionals are education and familiarisation. Most health care professionals are required to apply theoretical knowledge within the clinical setting when they engage in work integrated learning, also known as clinical placement. Al-Sagarat et al. (2015) assert that clinical placements are an important component of the nursing curriculum and can have an influence on attitude (Chadwick & Porter, 2014; Happell et al., 2015).

The Current Study

The aim of this quasi-experimental research was to determine whether a five-day non-traditional, TR-based mental health (MH) clinical placement affected nursing student's stigma surrounding mental illness, compared to nursing students attending a 'traditional' MH placement. Traditional MH clinical placements typically occur in hospital-based or service driven settings, where consumers are often at their most symptomatic and unwell. Therefore, this paper seeks to address the following questions:

- 1) Does a TR MH clinical placement reduce stigma towards mental illness in undergraduate nursing students?
- 2) Does the type of clinical placement impact on the level of reduction in stigma?
- 3) What are the benefits of TR clinical placements for nursing students with regard to stigma towards mental illness?

Methods

This study is a quasi-experimental design. It examines two student cohorts: intervention (attending Recovery Camp) and comparison (not attending Recovery Camp).

Measures were taken of both cohorts at three time intervals: pre-intervention, post-intervention, and again at 3 months follow-up. Ethics approval was sought from, and approved by, the relevant human research ethics committee prior to the project commencing. Prior to completing surveys, students provided written informed consent. Confidentiality was maintained by assigning each participant a code. Data was stored in a locked filing cabinet in a locked office at a tertiary institution.

Participants

Student participants were given the opportunity to express an interest in attending either Recovery Camp (intervention group) or a traditional MH clinical placement (comparison group) as part of their course requirements. Due to a limited number of places, researchers allocated students to a group after considering initial expressions of interest. Participants were not randomly assigned to either group. Those who applied for Recovery Camp and expressed suitable reasoning for wanting to attend, were invited to do so. Forty participants attended RC ($n = 20$ in 2014; $n = 20$ in 2015; 4 males, 36 females). A comparison group of 39 students who undertook traditional clinical placements in in-patient, sub –acute, forensic or community service driven mental health facilities in New South Wales, Australia ($n = 19$ in 2014; $n = 20$ in 2015; 7 males, 32 females), were also surveyed. Students were in their third year of undergraduate nursing studies at a tertiary institution.

Procedure

After informed consent was provided, students at Recovery Camp and also the comparison sites (traditional MH clinical placements) completed the Social Distance Scale

and a demographic information survey on three occasions. These were: within the week prior to placement, directly after placement (within one week of completion) and at three-month follow up. Participants for Recovery Camp were recruited through an email distributed to all third year nursing students. Participants for the comparison group were recruited through the distribution of flyers. A Research Officer – unaffiliated with the Nursing students – conducted recruitment. Students were contacted by phone or email for follow-up.

Clinical Placements for Undergraduate Nursing Students

Nurses comprise a substantial proportion of the health workforce. In 2012, the number of registered nurses (RNs) in Australia was 273,404 (Health Workforce Australia, 2014). Preparing nurses who are fit for practice, purpose and academic award is a key issue and requires an integration of theory and practice (Australian Nursing & Midwifery Accreditation Council [ANMAC], 2015). To graduate as competent and safe practitioners, nursing students are required to complete clinical placements as part of their Bachelor of Nursing. Placement hours vary among universities, with the Australian minimum being 800 hours, not inclusive of simulation activities (ANMAC, 2012). Clinical placements are an opportunity to engage in professional practice outside of a classroom context and provide opportunities to expose students to workplace conditions (Broadbent et al., 2014). Immersion within the practice setting is a crucial aspect of nurse education (Vinales, 2015) and one would hope that clinical placements, such as those in a mental health setting, would be one way of reducing stigma.

Reducing stigma in health care workers is critical not only to their professional development but also to the quality of care they provide. Clinical placements are a chance to learn more about particular populations and, theoretically, break down discriminatory ideology about particular groups of health service users, including people who have a mental

illness. Yet, variations may exist regarding the quality of clinical placements as an opportunity to reduce stigma. If such an assertion is correct, it is vital that clinical placements are reviewed to ensure that students are receiving the best placement options available for optimal learning and professional development.

Non-traditional Clinical Placements

Mental health clinical placements are increasingly more difficult to obtain. Given the challenges of placing students in traditional practice settings, like acute in-patient units, non-traditional placements are increasingly being considered. An example of this is Recovery Camp, based on the principles of therapeutic recreation (TR). Recovery Camp enables students to develop skills, confidence and competence in a non-clinical environment through a process of immersive familiarisation and education.

Recovery Camp

Recovery Camp is a five-day immersive, experiential mental health clinical learning program that occurs annually. Twenty undergraduate nursing students and 30 consumers living with severe and enduring mental illness are invited to attend. Recovery Camp provides an opportunity outside of the 'typical' inpatient, hospital / clinical setting. It aims to promote positive mental health nursing practice by facilitating building and maintaining therapeutic relationships through close collaboration with people who have a mental illness. This Australian 'bush camp setting' ensures familiarisation and close contact as a result of sharing meals and accommodation, working together as teams to collaboratively solve problems, bush dancing, winning (or not) at trivia, and participating in challenging activities like a 20m

flying fox (otherwise known as a zipline). Students 'learn' that mental illness is episodic and that consumers are more than their illness; they do this in the context of daily-lived experience. Importantly, it is made clear that everyone at camp is of equal status – that is, students have no more power (status) than consumers – as can be the case in traditional clinical settings. The research reported in this paper explores the impact of this clinical placement on undergraduate nursing students by examining its efficacy as a strategy to reduce stigma in comparison to students who attended a traditional clinical placement.

Social Distance Scale

The Social Distance Scale (SDS) (Link et al., 1987) was used to measure mental health stigmatisation among undergraduate nursing students. The SDS is a measure of the degree to which one desires to distance themselves from people with a mental illness. The scale contains seven statements; each statement is rated on a scale from 1 (certainly yes) to 5 (definitely no). Higher scores indicate a greater desire to distance oneself from someone with a mental illness. Social distance scales generally show good to excellent internal-consistency reliability ($r = .75$ to $.90+$) and acceptable construct validity (Link et al., 2004).

Data Analysis

Data analysis was completed using SPSS (Version 21, SPSS Inc., Chicago, IL, USA).

Results

A one-way analysis of variance (ANOVA) (using the general linear model) was performed to investigate the impact that the type of clinical placement had on reducing

stigma toward people with a mental illness by the students. The ANOVA (using the general linear model) indicated that SDS scores differed between the intervention and comparison groups, $F(1, 77) = 26.33, p < .001$. Parameter estimates indicated differences between groups pre-placement, post-placement, and at three-month follow up. Figure 1 shows the mean scores for the intervention and comparison group at each data collection point.

[FIGURE 1 TO BE INCLUDED ABOUT HERE]

Parameter estimates compared the total SDS score for the intervention group against the comparison group at each of the three time intervals. The intervention group scored significantly lower, compared to the comparison group at every time interval; pre-placement (95% CI – -4.41 to -1.19), $t(77) = -3.47, p = .001$; post-placement (95% CI – -6.83 to -3.09), $t(77) = -5.29, p < .001$; and 3-month follow up (95% CI – -6.92 to -2.63), $t(77) = -4.43, p < .001$.

Two separate repeated measures ANOVAs were performed to compare SDS scores for each group at each time interval (see Figure 1). The repeated measures ANOVA for the intervention group demonstrated that at least one sample was significantly different than the others, $F(2,78) = 77.5, p < .001$, partial $\eta^2 = .25$. Pairwise comparisons with a Bonferroni adjusted alpha revealed that within the intervention group there was a significant decrease in SDS scores between pre and post placement, as well as pre placement and three-month follow up, as shown in Figure 1. There was no significant difference between post placement and the three-month follow up. No significant differences were found within the comparison group at any time point.

Discussion

This study was conducted to determine whether a five-day therapeutic recreation (TR) based non-traditional mental health (MH) clinical placement affected nursing student's stigma surrounding mental illness, compared to students attending a 'typical' MH placement. Researchers sought to explore whether each clinical placement reduced stigma, and whether the type of clinical placement influenced variation in reported social distance for nursing students. Two groups of students participated in this study. One group attended a five-day Recovery Camp (RC; intervention group), while the other group attended a 'typical' mental health clinical placement (comparison group). Both groups completed the same social distance measure pre-placement, post-placement and at three-month follow up.

The Effect of Clinical Placement Type on Stigma

Analyses revealed that there was a significant difference in Social Distance Scale (SDS) scores between the intervention and comparison groups. Post hoc analyses showed that the intervention group reported a significantly lower level of stigma at all three time intervals. Importantly, the variance between groups increased significantly during the post-placement time interval. This suggests that not only were there qualitative differences between placement types, specifically, Recovery Camp was more successful in reducing stigma over a short and a long-term period compared to a typical MH clinical placement.

There was a significant effect of time for stigma scores for the intervention group. SDS scores decreased significantly between pre-placement and post-placement, which is indicative of an immediate positive effect of the intervention. This indicates that Recovery Camp was effective in reducing stigma toward consumers by undergraduate nursing students.

Furthermore, no significant differences in SDS scores between post-placement and the three-month follow up were found, indicating that Recovery Camp was effective enough to produce lasting results on student's perspectives toward people with a mental illness. It can be concluded that Recovery Camp appeared to have lowered stigmatisation towards people with a lived experience of mental illness.

The fact that there was no difference in SDS scores for the comparison group is troubling. As outlined earlier in this paper, stigmatisation is a significant issue among health care workers – particularly as it affects the quality of care they provide (Bennetts et al., 2013; Stuber et al., 2014). Stigma toward people who live with a mental illness is detrimental to their wellbeing and their recovery. Ensuring nurses are fully cognisant of the consequences of stigma on a person's physical and emotional wellbeing, and providing opportunities so that attitudes can be recognised and unlearned are important. Appropriate clinical placements, which facilitate a reduction in stigmatising attitudes, are essential to positive professional development. Findings from this study underscore the notion that traditional MH clinical placements may not be conducive to the lessening of stigma among health care workers. Non-traditional clinical placements, such as Recovery Camp, which enable, among other factors, students to become familiar with consumers when they are not at their most distressed, seem to be a potential solution to this. Students witness and appreciate the person, and not the illness.

This study looked at stigmatisation towards people with a mental illness across two groups: those who attended a typical MH clinical placement and those who participated in a TR-based clinical placement. Between groups, the consumers' stage of recovery at each differed significantly. Consumers who participated in Recovery Camp were all living in the community and were not hospitalised at the time they attended, though were still displaying significant negative and positive symptomology. Consumers within the typical placement

settings were, by definition, suffering more significant effects of their illness. The two placements also differed in terms of the nurses who facilitated the students' learning. Staff who preceptor students have a significant influence on whether a student has a positive experience on a placement, or not (Walker et al., 2012). The distinction between groups may account for the type of clinical experience had by nursing students – specifically, variance in stigma pre- and post-placement. Further studies are recommended to explore these factors.

Limitations

Participants were not randomly allocated to the Recovery Camp (intervention) or comparison group. As such, demographics and other variables were not controlled, calling into question the internal validity of the present research. Further, it ought to be cautioned that the present study focused on a small subset of nursing students from one university in Australia. The findings may not be generalisable to students from other institutions and regions. In addition, the current study did not explore participants' personal experience of, or familiarity with, mental illness prior to attendance at Recovery Camp. Future research should consider this as a potential confounding variable.

Future Research and Recommendations

This study explored the influence of a TR-based clinical placement on nursing student stigmatisation towards consumers. It is possible that certain aspects of Recovery Camp were more influential in decreasing stigma than others. Furthermore, there may have been a number of components within Recovery Camp that were absent from typical placements that may have contributed to the significant differences in stigma between students. Future

research should further explore the factors that are critical in influencing stigma reduction within Recovery Camp, and work towards implementing those factors within university teaching or hospital settings in order to achieve similar reductions in stigma towards people with a mental illness. This may be achieved through qualitative methods of data collection.

Conclusion

Recovery Camp appears to be an effective mode of reducing mental health stigmatisation for undergraduate nursing students. As a result of this immersive contact and familiarisation, students experienced a decreased desire for distance between themselves and people with a mental illness. Surprisingly, there was no variance in social distance scores for students who attended typical MH clinical placements. These findings give weight to the notion that change must be implemented to ensure nursing students receive the best possible education and clinical practice before entering the workforce to maximise the support and quality of care provided to consumers. This change should include immersion with people who live with a mental illness, outside a 'traditional' hospital setting, where therapeutic relationships can be built and maintained effectively. Education and clinical practice that emphasises recovery-oriented, strengths-based care is essential.

References

- Adair, C. E., McDougall, G. M., Mitton, C. R., Joyce, A. S., Wild, T. C., Gordon, A., Costigan, N., Kowalsky, L., Pasmaeny, G., & Beckie, A. (2005). Continuity of care and health outcomes among persons with severe mental illness. *Psychiatric Services*, 56(9), 1061-1069. <http://dx.doi.org/10.1176/appi.ps.56.9.1061>
- Al-Sagarat, A, Y., Al-Saraireh, F., Masa'deh, R., & Moxham, L. (2015). The impact of a mental health clinical placement on the clinical confidence of nursing students in Jordan. *Nurse Education Today*, 35(6), 760-764. <http://dx.doi.org/10.1016/j.nedt.2015.02.008>
- Angermeyer, M. C., Matschinger, H., & Corrigan, P. W. (2004). Familiarity with mental illness and social distance from people with schizophrenia and major depression: testing a model using data from a representative population survey. *Schizophrenia Research*, 69(2), 175-182. [http://dx.doi.org/10.1016/S0920-9964\(03\)00186-5](http://dx.doi.org/10.1016/S0920-9964(03)00186-5)
- Ashe, J. (2015). *The effects of personal contact on attitudes toward mental illness in baccalaureate nursing students*, University of Akron, Ohio: Honours Research Project. Paper 55. Retrieved from http://ideaexchange.uakron.edu/cgi/viewcontent.cgi?article=1121&context=honors_research_projects
- Australian Nursing & Midwifery Accreditation Council (2012). *Registered nurse accreditation standards*. Retrieved from: http://www.anmac.org.au/sites/default/files/documents/ANMAC_RN_Accreditation_Standards_2012.pdf
- Australian Nursing & Midwifery Accreditation Council (2015). *Accreditation services*. Retrieved from: <http://www.anmac.org.au/accreditation-services>

- Bennetts, W., Pinches, A., Paluch, T., & Fossey, E. (2013). Real lives, real jobs: Sustaining consumer perspective work in the mental health sector. *Advances in Mental Health*, 11(3), 3687–3720. <http://dx.doi.org/10.5172/jamh.2013.11.3.313>
- Boyd, J. E., Adler, E. P., Otilingam, P. O., & Peters, T. (2014). Internalized stigma of mental illness (ISMI) scale: A multinational review. *Comprehensive Psychiatry*, 55(10), 221-231. <http://dx.doi.org/10.1016/j.comppsy.2013.06.005>
- Broadbent, M., Moxham, L., Sander, T., Walker, S., & Dwyer, T. (2014). Supporting bachelor of nursing students within the clinical environment: Perspectives of preceptors. *Nurse Education in Practice*, 14(4), 403-409. <http://dx.doi.org/10.1016/j.nepr.2013.12.003>
- Byrne, L., Happell, B., Welch, T., & Moxham, L. (2013). Things you can't learn from books: Teaching recovery from a lived experience perspective. *International Journal of Mental Health Nursing*, 22(3), 195-204. <http://dx.doi.org/10.1111/j.1447-0349.2012.00875.x>
- Chadwick, L., & Porter, J. (2014). An evaluation of the effect of a mental health clinical placement on the mental health attitudes of student nurses. *Nursing and Health*, 2(3), 57-64. <http://dx.doi.org/10.13189/nh.2014.020301>
- Cook, J. E., Purdie-Vaughns, V., Meyer, I. H., & Busch, J. T.A. (2014). Intervening within and across levels: a multilevel approach to stigma and public health. *Social Science and Medicine*, 103, 101-109. <http://dx.doi.org/10.1016/j.socscimed.2013.09.023>
- Corrigan, P. W. (1998). The impact of stigma on severe mental illness. *Cognitive and Behavioral Practice*, 5(2), 201–222. [http://dx.doi.org/10.1016/S1077-7229\(98\)80006-0](http://dx.doi.org/10.1016/S1077-7229(98)80006-0)

- Corrigan, P. W., Watson, A. C., Marpinski, A. C., & Gracia, G. (2004). Implications of educating the public on mental illness, violence and stigma. *Psychiatric Services*, 55(5), 577-580. <http://dx.doi.org/10.1176/appi.ps.55.5.577>
- Corrigan, P., & Gelb, B. (2006). Three programs that use mass approaches to challenge stigma of mental illness. *Psychiatric Services*, 57(3), 393-398. <http://dx.doi.org/10.1176/appi.ps.57.3.393>
- Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest*, 14(2), 37-70. <http://dx.doi.org/10.1177/1529100614531398>
- Couture, S., & Penn, D. (2003). Interpersonal contact and the stigma of mental illness: A review of the literature. *Journal of Mental Health*, 12(3), 291-305. <http://dx.doi.org/10.1080/09638231000118276>
- Drapalski, A. L., Lucksted, A., Perrin, P. B., Aakre, J. M., Brown, C. H., DeForge, B. R., & Boyd, J. E. (2013). A model of internalized stigma and its effects on people with mental illness. *Psychiatric Services*, 64(3), 264-269. <http://dx.doi.org/10.1176/appi.ps.001322012>
- Griffiths, K. M., Carron-Arthur, B., Parsons, A., & Reid, R. (2014). Effectiveness of programs for reducing the stigma associated with mental disorders: a meta-analysis of randomized control trials. *World Psychiatry*, 13(2), 161-175. <http://dx.doi.org/10.1002/wps.20129>
- Happell, B., Gaskin, C. J., Byrne, L., Welch, A., & Gellion, S. (2015). Clinical placements in mental health: A literature review. *Issues in Mental Health Nursing*, 36(1), 44-51. <http://dx.doi.org/10.3109/01612840.2014.915899>
- Henderson, C., Noblett, J., Parke, H., Clement, S., Caffrey, A., Gale-Grant, O., Schulze, B., Druss, B. & Thornicroft, G. (2014). Mental health-related stigma in health care and

- mental health settings. *The Lancet Psychiatry*, 1(6), 467-482.
[http://dx.doi.org/10.1016/S2215-0366\(14\)00023-6](http://dx.doi.org/10.1016/S2215-0366(14)00023-6)
- Hunter, L., Weber, T., Shattell, M., & Harris, B. A. (2015). Nursing students' attitudes about psychiatric mental health nursing. *Issues in Mental Health Nursing*, 36(1), 29-34.
<http://dx.doi.org/10.3109/01612840.2014.935901>
- Johnson, R. J., Turner, R. J., & Link, B. G. (2014). (Eds). *Sociology of mental health: Selected topics form forty years 1970s-2010s*. New York, NY: Springer.
- Link, B. G., Cullen, F. T., Frank, J., & Wozniak, J. F. (1987). The social rejection of former mental patients: Understanding why labels matter. *American Journal of Sociology*, 92, 1461-1500. <http://dx.doi.org/10.1086/228672>
- Link, B. G., & Phelan, J.C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, 27, 363-385. <http://dx.doi.org/10.1146/annurev.soc.27.1.363>
- Link, B. G., & Phelan, J. C. (2006). Stigma and its public health implications. *The Lancet*, 367(9509), 528-529. [http://dx.doi.org/10.1016/S0140-6736\(06\)68184-1](http://dx.doi.org/10.1016/S0140-6736(06)68184-1)
- Link, B. G., Yang, L. H., Phelan, J. C., & Collins, P. Y. (2004). Measuring mental illness stigma. *Schizophrenia Bulletin*, 30, 511-541.
- Mestdagh, A., & Hansen, B. (2013). Stigma in patients with schizophrenia receiving community mental health care: A review of qualitative studies. *Social Psychiatry and Psychiatric Epidemiology*, 49(1), 79-87. <http://dx.doi.org/10.1007/s00127-013-0729-4>
- Michaels, P. J., Corrigan, P. W., Buchholz, B., Brown, J., Arthur, T., Netter, C., & Macdonald-Wilson, K.L. (2014). Changing stigma through a consumer-based stigma reduction program, *Community Mental Health Journal*, 50(4), 395-401.
<http://dx.doi.org/10.1007/s10597-013-9628-0>

- Miller, C. L., Druss, B. G., Dombrowski, E. A., & Rosenheck, R. A. (2003). Barriers to primary medical care among patients at a community mental health centre. *Psychiatric Services*, 54(8), 1158-1160. <http://dx.doi.org/10.1176/appi.ps.54.8.1158>
- Murman, N. M., Buckingham, K. C., Fontile, P., Villanueva, R., Leventhal, B., & Hinshaw, S. P. (2014). Let's erase the stigma (LETS): A quasi-experimental evaluation of adolescent-led school groups intended to reduce mental illness stigma. *Journal of Research and Practice in Children's Services*, 43(5), 621-637. <http://dx.doi.org/10.1007/s10566-014-9257-y>
- Nordt, C., Rössler, W., & Lauber, C. (2006). Attitudes of mental health professionals toward people with schizophrenia and major depression. *Schizophrenia bulletin*, 32(4), 709-714. <http://dx.doi.org/10.1093%2Fschbul%2Fsbj065>
- Phelan, J. C., Lucas, J. W., Ridgeway, C. L., & Taylor, C. J. (2014). Stigma, status and population health. *Social Science and Medicine*, 103, 15-23. <http://dx.doi.org/10.1016/j.socscimed.2013.10.004>
- Rosenberg, H. (2014). Reducing stigma through contact: Three examples from the sociology of mental illness. *Currents in Teaching and Learning*, 7(1), 108-116.
- Stuber, J. P., Rocha, A., Christian, A., & Link, B. G. (2014). Conceptions of mental illness: Attitudes of mental health professionals and the general public. *Psychiatric Services*, 65(4), 490-497. <http://dx.doi.org/10.1176/appi.ps.201300136>
- Thornicroft, G., Mehta, N., Clement, S., Evans-Lacko, S., Doherty, M., Rose, D., Koschorke, M., Shidhaye, R., O'Reilly, C., & Henderson, C. (2015). Evidence for effective interventions to reduce mental health related stigma and discrimination, *The Lancet*, [http://dx.doi.org/10.1016/S0140-6736\(15\)00298-6](http://dx.doi.org/10.1016/S0140-6736(15)00298-6)
- Vinales, J. J. (2015). Exploring failure to fail in pre-registration nursing. *British Journal of Nursing*, 24(5), 284-288. <http://dx.doi.org/10.12968/bjon.2015.24.5.284>

Walker, S., Dwyer, T., Moxham, L., Broadbent, M., & Sander, T. (2012). Facilitator versus preceptor: Which offers the best support to BN students? *Nurse Education Today*, 33(5), 530-535. <http://dx.doi.org/10.1016/j.nedt.2011.12.005>